TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

ONPATTRO ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Onpattro

☐ Weight of less than 100kg: Onpattro 0.3mg/kg IV once every three weeks

☐ Weight of 100kg or greater: Onpattro 30mg IV once every three weeks

✓ Prescriber should advise patient to supplement with recommended daily allowance of Vitamin A

✓ Pre-Medications will be given as indicated below unless otherwise specified

Refills for one year from date of signature unless indicated below.

_____ Refills

PRE-MEDICATIONS

Oral

✓ Acetaminophen: _____ 325mg __X__ 500mg _____ 650mg
☐ Loratadine: 10mg
☐ Cetirizine: 10mg
☐ Diphenhydramine: _____ 25mg _____ 50mg
☐ Famotidine: _____ 20mg _____ 40mg
☐ Ibuprofen: _____ 200mg _____ 400mg _____ 600mg
☐ Ondansetron: _____ 4mg _____ 8mg
☐ Other: _____

IV

✓ Dexamethasone: _____ 4mg _____ 8mg __X__ 10mg
✓ Diphenhydramine: _____ 25mg __X__ 50mg
✓ Famotidine: __X__ 20mg _____ 40mg
☐ Methylprednisolone: 125mg
☐ Hydrocortisone: 100mg
☐ Ondansetron: _____ 4mg _____ 8mg
☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date